General Information

1 DEFINITION OF 'MAJOR INCIDENT'

1.1 There is no standard definition of a 'major incident' which would satisfy the Health Service, the emergency services and local authorities, each tending to look at such incidents from the point of view of its own responsibilities. The purpose of planning for emergencies in the NHS is to ensure preparedness for an effective response to any major incident resulting in an abnormal demand upon health care services.

1.2 A widely accepted definition of a major incident is "any emergency that requires the implementation of special arrangements by one or more of the emergency services, the NHS or the local authority". Within that broad definition, each of the agencies concerned must determine such incidents in the light of its own responsibilities.

1.3 Any agency with the power to declare a major incident must take into account the impact likely to be felt by any other agency or service involved. Declaration should be considered where the effect on any part of the system is likely to be disproportionately large. It may be necessary when, for instance, additional special resources such as intensive care beds, operating theatre resources, or burns facilities will be required, even though the total number of casualties is limited.

2 INITIATION

2.1 Under normal circumstances, the Ambulance Service will declare a Major Incident, Central Ambulance Control (Waterloo) will relay the Major Incident message to Receiving Hospital Switchboards. The Ambulance Control Duty Officer will be aware of the capacity and limitations of the hospitals being alerted and to whom casualties might be despatched.

2.2 The Hospital nominated as the 'Designated Receiving Hospital' will receive the majority of the casualties, the 'Supporting Hospitals' may be called upon to send a mobile medical and nursing team to the incident site. Any 'Supporting Hospital' may be asked to take transferred patients from the 'Designated Hospital' to allow them to deal with patients from the incident.

2.3 In the event of a BHR Hospital being nominated as the 'Designated Receiving Hospital' it is likely that routine outpatients clinics and operations will need to be cancelled for the day to allow staff to respond to the incident. The Medical Director will make this decision for the hospital.

3 MAJOR INCIDENT – PLAN ACTIVATION

3.1 When alerting a hospital, Ambulance Control should always give the following additional information:-

a) type of incident
b) location of incident
c) time of incident
d) estimated number of casualties
e) predominant nature of injuries, if known
f) time of message
g) which other hospitals (if any) have been alerted
h) the name of the person giving the information and the name of the person receiving it.

3.2 Upon receipt of the message from the Ambulance Service, the Switchboard Operator will contact the Duty Matron/Site Manager and the Nurse-in-Charge of the Accident and Emergency Department and relay the message received from Ambulance Control.

3.3 The Duty Matron/Site Manager will instruct the switchboard operator to instigate the major incident call-out procedure and will be responsible for setting up the Major Incident Control Centre and issue action cards to key action card holders held in the Major Incident Control Centre cupboard(s).

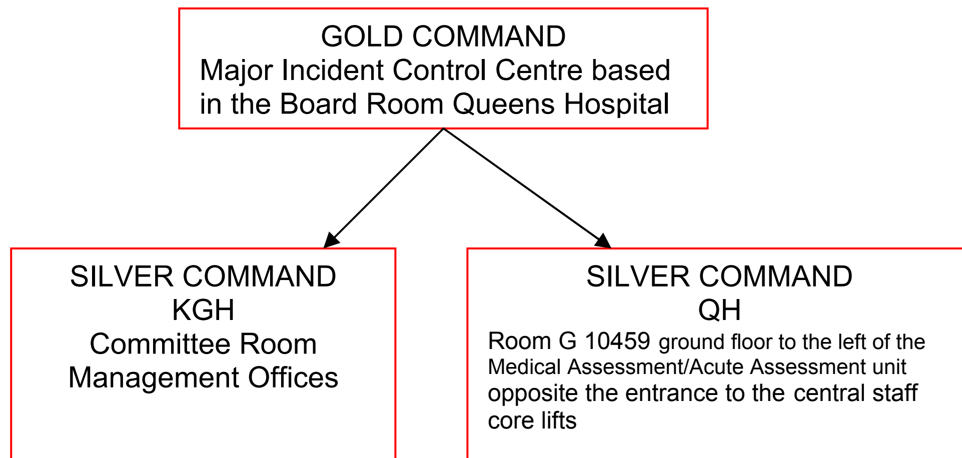
3.4 The Nurse-in-Charge of the Accident and Emergency Department will prepare the department to receive casualties from the major incident.

3.5 The Major Incident Control Centres will be staffed by the Duty Matron Site Manager Physician/Surgeon On-Call (depending on the nature of the incident), the Duty/On-Call Director, the Communications Manager or appropriate deputies. The Control Centre will receive all messages passing to and from the hospital, it will co-ordinate all activities. This room should not be overcrowded by others.

3.6 The Strategic Major Incident Control Centre will be set up in the Boardroom in Trust Headquarters Queens Hospital and will be staffed by the Chief Executive, Medical Director, Director of Nursing and the Communications Manager or appropriate deputies.

Major Incident Control Centres

3.7



4 SUMMARY OF ROLE OF MAJOR INCIDENT CONTROL CENTRE(S)

4.1 To co-ordinate and oversee that the plan has been implemented and to provide up-to-date situation reports to the strategic control centre.

5 SUMMARY OF ROLE OF STRATEGIC MAJOR INCIDENT CONTROL CENTRE

5.1 The role and function of the 'Gold' Major Incident Control Centre is to plan for the continuation of the Trust's core business during and in the aftermath of a major incident and would act as 'Gold Command'

5.2 The responsibility of the Gold Control Centre is to ensure that all Trust resources are utilised and deployed in areas where the demand may exceed the norm.

5.3 The Gold Control Centre will be responsible for the planning and implementation of a structured recovery plan for any services that may have been cancelled because of the major incident. This would include liaison with Primary Health Care Trusts to explore the possibility of utilising key P.C.T. staff i.e. doctors, nurses, allied healthcare professionals should BHURT staffing resources become exhausted.

5.4 The Strategic Control Centre will receive regular updates from the receiving hospital(s) control centre(s) and be responsible for relaying information

concerning the Trust's activities i.e. number and types of casualties, to the Strategic Health Authority and Primary Health Care Trust(s). A member of the gold team would be responsible for setting up a dedicated 'helpline' for enquiries regarding the major incident ensuring that members of the public were directed to the Police Casualty Bureau regarding victims/survivors.

5.5. To summarise, the Strategic Control Centre will adopt a supportive role in relation to the bronze major incident centre(s) whilst also planning and instigating the operational recovery plan from the longer-term cause and effect of the major incident.

6 LOCATION OF MAJOR INCIDENT CONTROL CENTRES

6.1 King George Hospital – situated in the Committee Room, Management Offices – Ext 8448.

6.2 Queens Hospital - situated in Room G 10459 ground floor to the left of the Medical Assessment/Acute Assessment unit opposite the entrance to the central staff core lifts Ext 2434.

6.3 Each Control Centre is equipped with telephones, facsimile, e-mail and Internet facilities.

6.4 Casualties will be brought to the hospital by ambulances and will pass through the triage point in the A&E Department blue light corridor. (This is to be the only entrance to the department in use for patients). Casualties will be directed as appropriate for treatment to the Resuscitation Room, Trolley Bay or Waiting Area according to the severity of their injuries. If there are a large number of casualties designated areas will also be used for treatment of the casualties. Where necessary, patients might be taken directly to the operating theatres to enable treatment to commence as quickly as possible and to prevent a 'log jam'. Depending upon the incident, a number of patients will require admission, some will be discharged home once they have been treated.

6.5 The documentation of patients is vitally important and will be carried out by Accident and Emergency/Medical Records staff who will have hot 'packs' provided. They will be stationed at each treatment point.

6 AMBULANCE LIAISON OFFICER

6.1 The Ambulance Liaison Officer will be based in the Accident and Emergency Department near to the ambulance radio point. The Ambulance Liaison Officer has responsibility for passing information between the Trust Major Incident Control Centre, the Emergency Control Vehicle and Central Ambulance Control.

6.2 The Ambulance Liaison Officer is also responsible for managing ambulances that arrive at the hospital.

7 POLICE DOCUMENTATION TEAM

8.1 The Police Liaison Officer will be responsible for establishing a Casualty Information Service. The Police will be the sole source of information about casualties and will brief the Press as appropriate. Any enquiries received by Switchboard will be diverted to the enquiries line set up by the Police. The Police will be responsible for setting up a communication systems unit within the Security Office this will record details of casualties from the Major Incident, including casualties dealt with at the site without referral to the hospital, and to answer all initial enquiries. Police will also provide a uniformed presence for security purposes in conjunction with the Trust's Security Officers.

9 RECEIVING WARD(S)

9.1 To enable casualties to be admitted, it will be necessary to discharge home or transfer patients to other hospitals. Designated wards may be used depending on specialised requirements. Transfers and discharges will be made by ambulance or private transport.

10 COMMUNICATIONS

10.1 Communication in all its forms will be the success of any Major Incident Procedure. In the reviews of all large scale accidents, the success or otherwise of the communications has always figured significantly. Communication exercises (COMMEX) will be undertaken at least every 6 months, in line with the guidance set out in Communications Exercise Protocol (*Health Emergency Protection Agency)*

10.2 Staff should not use telephones if this can be avoided throughout the emergency. If calls are necessary, then public call boxes and direct lines only should be used, If possible, messages should be conveyed by hand. Porters and volunteers may act as runners. As there is likely to be a large press/public presence, mobile phones should not be used by hospital staff as communication lines are likely to become congested.

10.3 The Switchboard will keep all key staff contact numbers and these will be updated and maintained. The incident will be subject to review in order to assess response and change the plan if needed.

11 PRESS ARRANGEMENTS

11.1 The Press will be provided with accommodation (refer to Action Card 21 in the King George Hospital Major Incident Plan and Action Card 109in the Queens Hospital Major Incident Plan). Arrangements for dealing with the Press will develop with the severity of the incident and the Police Liaison Officer will be a key contact for involving the resources of the Police in handling this.

12 DEALING WITH VIP VISITS

12.1 Incidents that involve casualties often prompt visits by VIPs which in turn attracts significant media attention. The responsibility of dealing with these matters falls to the Associate Director - Communication and Corporate Services. Any member of staff who is aware of any high profile visit or media attention should contact the Associate Director – Communication and Corporate Services or the On-call Press Officer via the switchboard and update them of the situation.

13 CHILDRENS NEEDS

13.1 The Major Incident Plan applies to incidents, which include children, however some incidents may have a high proportion of children or be exclusively children.

13.2 Children involved in a Major Incident will be triaged in the Paediatric Accident and Emergency Department and if deemed necessary admitted to a Paediatric Ward where Paediatric-trained anaesthetists, surgeons, orthopaedic doctors and Registered State Children's Nurses will treat them.

14 RECEPTION OF RELATIVES

14.1 Areas will be assigned for use by relatives and an officer assigned to look after them.

15 STAFF WELFARE

15.1 It is important that staff involved in the management of a Major Incident receive the offer of support/counselling. Counselling Services can be accessed through the Occupational Health Department by any member of staff requiring this service

(BHURT – Counselling Policy)

16 HEALTH AND SAFETY

16.1 It is the responsibility of all individuals to ensure that health and safety Regulations are adhered to in order minimise the risk to patients and staff.

(*BHRT Safety Policy)*

17 HOSPITAL STAND DOWN

17.1 A phased stand down of the hospital(s) will be co-ordinated by the Major Incident Control Centre(s), but will depend upon hospital activity. It is likely that the A&E Department will be stood down early, but theatres and support services may be overwhelmed for some considerable time and depending on the incident, many hospital services may be affected for days to come. The stand down therefore applies to the acute phase of activity, when new patients

stop presenting at the hospital(s) the Medical Director is responsible for co-ordinating this process.

18 DEBRIEF

18.1 The Senior Chaplain will be responsible for the co-ordination of a short debrief in the aftermath of a Major Incident in order to discuss any immediate problems. Key personnel will be required to submit a report, in writing, to the Director of Nursing as soon as possible after the incident is closed.

18.2 A full multi agency debrief will be held within 48 hours lead by the Director of Nursing or nominated deputy, in order to review policy and procedure.

19 ON-SITE EMERGENCIES

19.1 The definition of an on-site emergency is an incident which causes disruption to the normal function of the hospital, such that patients and/or staff are at risk

19.2 Many minor incidents occur on a day-to-day basis. These are common but easily countered. Failures of power supply, steam shutdowns and the like are examples. There are an enormous number of possibilities which fall into this "middle" classification and which require special arrangements by the Trust. Essentially, the initial question is "can the hospital continue functioning with support or must all (or part of the hospital) be relocated?".

19.3 The Duty Matron/Site Manager has the responsibility of declaring an on-site emergency and will set up the Major Incident Control Centre, which will be staffed by appropriate personnel in order to deal with the emergency. -
(*BHRT – Hospital On Site Emergency Procedure).*

20 REMOVAL AND CUSTODY OF BODIES

20.1 The overall responsibility for all matters concerning deceased casualties lies with Her Majesty's Coroners. The Police, acting for the Coroner, will make arrangements for temporary charge of bodies. Deceased casualties should not be taken to receiving hospitals. Care should be taken not to disturb materials or debris that may be of forensic or medico-legal importance. Attention is drawn to the *Home Office publication "Dealing with Fatalities during Disasters" (ISBN 1-874321-094).*

21 SECTOR CO-ORDINATING TEAM

21.1 On-call delegates from the Strategic Health Authority, Lead Primary Care Trust and Health Protection Unit known as the Sector Co-ordinating Team have the responsibility of managing the co-ordination of the NHS response within the sector, employing the operational co-ordination and support of the PCT response and the co-ordination of the Public Health response.

22 ROLE OF PRIMARY HEALTH CARE TRUSTS

22.1 Primary Health Care Trusts are responsible for providing a 24-hour Emergency Management and Clinical response, if required they can arrange for the treatment of minor casualties at reception centres, minor injury centres, walk-in centres, community hospitals and general practice. They can also assist acute hospitals by providing staff where appropriate and supporting accelerated discharge, they will co-ordinate community hospital's bed capacity in liaison with the emergency bed service and local hospitals.

23 LOCAL AUTHORITIES

24.1 The role of local authorities is to provide resources and facilities that will offer assistance and relief to those affected and co-ordinate the services of the voluntary sector and other agencies; the central aim being to restore the community and local environment to 'normal' as soon as is possible. Local authorities possess vast resources in terms of personnel, equipment and facilities that can assist in the co-ordinated response to a major incident.

24.2 Initially the local authority will act in a supporting role of the emergency services, however in the medium to longer term, dependent upon the nature of the incident, will assume the lead role.

25 VOLUNTARY SERVICES

25.1 There will be a requirement for all other supporting services to be available, including Voluntary Services to look after the relatives.

26 ASSESSMENT OF LOCAL HAZARDS AND RISKS

26.1 Trust in conjunction with it's neighbouring Local Authorities is required to be aware of the local hazards and risks, which are held in the Local Authorities Risk Register such as large complex railway and underground systems, motorways, COMAH sites, shopping complexes and rivers. As these are all within its catchment area may result in the Ambulance Service declaring a Major Incident which in turn will necessitate Barking Havering and Redbridge Hospitals NHS Trust acute hospital(s) invoking its Major Incident Plan.

(*Civil Contingencies Act 2004)*

27 PLANNING AND TRAINING

27.1 No two incidents are the same. The effects of any major incident are likely to be complex and unpredictable and no single model or blueprint exists for dealing with these. Whatever the nature of the incident, the basic principles of emergency planning remain the same.

27.2 The Major Incident Plan is vital, but staff must be properly trained and equipped to respond to the unpredictable.

27.3 The Major Incident Plan is the responsibility of the Director of Nursing. There is a Multi-disciplinary Planning Group under the chairmanship of the Director of Performance and Planning with delegated authority from the Chief Executive. The group has multi-disciplinary representation from all clinical and corporate directorates and external agencies. It is responsible for regularly updating and testing the plan. It meets quarterly and the plan is updated and tested annually.

27.4 The Trust has a nominated Emergency Planning Adviser who performs the following roles:

- Ensures that the Major Incident Plan meets the criteria set out in the Department of Health - Emergency Planning Guidance 2005
- Ensures compliance with the Cabinet Office Civil Contingencies Act 2004.

- Informs the Trust of any recommendations or directives from Cabinet Office, Department of Health, Home Office, National Audit Office, Health Protection Agency and other agencies.

- Conducts an annual review and revision of the Major Incident Plan, ensuring that appropriate emergency planning requirements are present in service specifications.

- Takes the lead in planning and training, develops an ongoing programme of staff training, including attendance at external courses, and maintaining a register of training that has taken place.

28 EXERCISES

28.1 The Plan will be validated and the competencies of staff tested by exercises at regular intervals by:

- Simple familiarisation visits and inspection of equipment.
- Table Top Exercises – annually - based on imagined scenarios.
- Live exercises – 1 every 3 years.
- Communication exercises to test the response to the Major Incident call-out procedure.

29 ANNUAL REVIEW

29.1 The Major Incident Plan will be reviewed annually or more frequently to reflect service changes.

30 CONCLUSION

30.1 Although most Major Incidents appear to happen outside normal working hours when there are problems of locating staff, an incident during working hours is equally demanding and is still a major problem. Whilst there are more staff immediately available, the hospital will also contain many outpatients, possible large numbers of visitors and theatres will probably be occupied by elective cases. All of these would have to be dealt with and as many as possible cleared from the building which would give an additional task to those already listed.

30.2 We must exercise various routines to ensure that we are as efficient and effective under these abnormal conditions as we are during the normal working day.

30.3 It is everyone's responsibility to ensure that they are aware of the procedures and that new staff receive appropriate information and training.

30.4 It is the responsibility of each ward and department to develop internal procedures to respond to Major Incident and to ensure that all staff are aware of these.